

A New Ambition for Old Age

*Next Steps in Implementing the National
Service Framework for Older People*

A Resource Document

*from Professor Ian Philp,
National Director for Older People,
Department of Health*



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Contact details	Professor Ian Philp's Office Richmond House 79 Whitehall London SW1A 2NL 020 7210 5916 www.dh.gov.uk
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Preface

The changing demographics of our society present us with a tremendous challenge – and a once-in-a-lifetime opportunity if we grasp it. By 2007 there will be more people over 65 than under 18. The over 85s are the fastest growing segment of the population, set to double in number by 2020.

We should celebrate this. An ageing population is not a burden – it's a benefit. Older age should be a time to enjoy the rewards flowing from years of service to the community and helping their own families to grow and develop into independence.



That is why I welcome Professor Philp's report on the future of the Older People's NSF, because it identifies the key challenges for the future, and has as its proper aim that older people should be treated with respect for their dignity and human rights in all care settings, whether at home, in hospital or in a care home.

We cannot say this currently applies everywhere in the care system, which is why I am determined to raise standards of care for all older people.

Looking at progress so far it is clear that the NSF has been the focus for major advances, as in promoting older people's access to health promotion and elective health care, as well as dramatically reducing delayed discharge from hospital and increasing the proportion of older people with high levels of need to remain in their own homes for longer. Increased investment by this Government in the NHS and social care has enabled us to lead the world in some areas, like intermediate care.

But Professor Philp recognises in the report that along with this must go changing the often negative culture of attitudes towards older people so they are valued and respected. This is found in some staff who work in the NHS and social care as well as in the independent and private sectors – we need zero tolerance of these views and a target that in five years time no older person or their carers will be treated with anything other than dignity.

Older people and their families want more services for strokes, falls, mental health, long-term conditions and emergency care, all of which are highlighted in the report as areas of renewed action and attention in this second stage of the NSF. Furthermore, those entering old age want to know how to maintain their health, independence and well-being.

In the next phase of health and social care reform we must place older people's needs at the centre and involve them and their representatives in care planning. For like all other citizens they have the right to choice, to respect, to equality of access to treatment and services and to the maintenance of their dignity.

Clearly society's age structure is changing and there are very clear plans set out here in these ten programmes for all of us to respond to the challenge.

A handwritten signature in black ink, appearing to read 'Liam Byrne'.

Liam Byrne MP
Minister for Care Services

Progress to Date

A National Service Framework for Older People was published in March 2001. It set national standards for the health and social care of older people in England and guidance on medicines management.

In November 2004, I published *Better Health in Old Age*, reporting on progress in implementing the National Service Framework.

Much progress has been made. There has been a steady increase in the proportion of older people receiving intensive help to maintain a high quality of life independently at home rather than in residential care, with nearly one third (32%) now in this group.¹

Delayed discharge from acute hospitals has been reduced by more than two thirds.

Through tackling age discrimination, older people are receiving access to treatment and services in greater numbers than ever before.

Specialist services for age-related needs, such as stroke and falls, continue to improve.

Increasing numbers of older people are taking advantage of health promotion opportunities, for example in stopping smoking.

But much more needs to be done. The review of NSF implementation published by the Healthcare Commission, Commission for Social Care Inspection and Audit Commission in March 2006 identifies key challenges for the next phase.

A New Ambition

Just as the NSF was developed with input from older people and their relatives, our new ambition reflects what older people have told me what they want of the new care system.

Although overt age discrimination is now uncommon in our care system, there are still deep-rooted negative attitudes and behaviours towards older people. Within five years, our ambition is to ensure that older people and their families will have confidence that in all care settings, older people will be treated with respect for their dignity and their human rights.

1 Source: Health and Social Care Information Centre

Caring for frail older people is core business in the NHS and in social care. The White Paper *Our health, our care, our say* creates the opportunity to align the planning, commissioning and delivery of health and care for frail older people. Not only can we improve outcomes for older people's health, independence and well-being. We can also save money by reducing the overall demand for expensive hospital and long-term care services.

Finally, we want to extend healthy life expectancy. For many older people, later life is associated with enhanced well-being, with time for reflection, for friendship and for engagement in the lives of their families and local communities. We want to ensure that older people have greater opportunities to enjoy old age.

Our ambition will be achieved through ten programmes of activity, the aims of which are described below. We also describe some of the main levers for implementation. More detailed information is provided in this Resource document.



Professor Ian Philp
National Director for Older People



Ten Programmes under Three themes: Dignity in Care, Joined-Up Care, and Healthy Ageing

Dignity in Care

Older people are more likely than younger people to become seriously ill and to face the prospect of dying. They and their families need to know that they will be treated with respect for their dignity if they become ill and that they will receive good end of life care. Older people are the main users of hospital and residential services. There have been high profile cases of poor treatment of older people in mental health and general hospitals, in care homes and in domiciliary care. It is important that care in all these settings is geared to the needs of older people, especially for those approaching the end of their lives. Our work will seek to challenge deep-seated negative cultural attitudes towards older people, the root cause of failure to treat older people with respect for their dignity and human rights.

Programme 1: Dignity in Care



Concerns about lack of respect for the dignity of older people in care settings were a major reason for needing an NSF for older people. In the NSF, standards were set for mental health care (Standard 7), acute hospital care (Standard 4) and for the more general principles of person-centred care (Standard 2) and rooting out age discrimination (Standard 1) which apply to all care settings. Underpinning programmes in leadership development, skills and competencies frameworks for staff, benchmarking and audit, adult protection procedures and environmental transformation were implemented. Our definition of dignity is based on the moral requirement to respect all human beings, irrespective of any conditions they may suffer from¹.

However, there are still reports that the experience of many older people remains unacceptable. A renewed commitment to ensuring respect for the dignity and human rights of older people will be central to the delivery of care in all care settings.

1 For further information refer to the Dignity and Older Europeans project <http://www.cf.ac/dignity>

Aims:

We will strengthen activities in the following areas:

- **Nutrition and the physical environment**
Continuing to improve and upgrade the patient environment in hospitals and care homes, ensuring that the environment of care more closely meets the needs of older people and they receive the assistance they require with eating and drinking.
- **Skills, competence and leadership in the workforce**
Improving skills and competencies across the workforce and developing identifiable or named practice based leaders in nursing, who will be accountable for ensuring older people are treated with respect for their dignity.
- **Assuring quality**
Working closely with the inspectorates and regulators to ensure the issue of dignity is central to their work, so that breaches of dignity are regarded as serious failures.
- **Ensuring dignity for those with mental health problems**
Working with the Older People's Mental Health programme to implement the service development guide for older people's mental health.
- **Ensuring dignity at the end of life**
Working alongside the NHS End of Life Care Programme to deliver best practice end of life care for older people in hospitals, care homes and in their own homes.
- **Equalities and human rights**
The link to the wider Government work on equalities and human rights, notably the establishment of a Commission for Equalities and Human Rights in 2007.
- **Championing Change**
Informing and raising awareness amongst care providers, staff and older people's champions of unacceptable standards of care on behalf of older people and their families, and involving older people as citizens and service users to help improve services and ensure dignity in care.

Further resources

- *Moving on: key learning from Rowan Ward* (Gateway Reference 4763) (CSIP, 2005). Following on from the review of inpatient wards for older people with mental health problems in England, this document was produced by the Care Services Improvement Partnership to share learning, provide information and useful contacts to all those working to services for older people with mental health problems.
<http://www.dh.gov.uk>

- *Report on the Standard 4 Transformational Projects* (Gateway Ref 5911) (DH, 2005). In September 2003 £5.6 million was announced over to two years to support implementation of Standard 4 (General Hospital Care) of the NSF for Older People. Forty projects received central funding, this report provides information about all the projects, their progress and achievement to date. Available at www.dh.gov.uk
- *The Dignity and Older Europeans Project*
Dignity & Older Europeans is an international three year research project funded by the European Commission which brought together a range of academics, clinicians, and user groups to explore the concept of dignity in the lives of Older Europeans. It particularly focused older people's experiences of health and social care. To read more about the findings of the project please go to www.cf.ac.uk/dignity

Programme 2: Dignity at the end of life



The NSF for Older People captures the key principles of good end of life care. Much of best practice in end of life care has been developed for people dying from cancer. Three models show particular promise for adaptation and use for end of life care of other groups. These are the Liverpool Care Pathway for the dying, the Gold Standards Framework and (in an earlier stage of development) the Preferred Place of Care Model.

A national project, with a budget of £12 million over three years has been established to support spread of best practice in end of life care to non-cancer groups. Feedback from strategic health authorities and external stakeholders has identified the need to improve end of life care for people living in care homes as a priority.

Aims:

1. To adapt and spread the three best practice models, as appropriate, for end of life care of older people living at home (GSF, PPC, LCP) or in hospital (LCP, PPC), in line with other adult needs.
2. To facilitate best practice in commissioning, delivery and education in end of life care in care homes.

Further Resources

- *Year One Progress Report on End of Life Care Programme* (DH/NHS, 2006) (Gateway ref 6268) – www.endoflifecare.nhs.uk
The End of Life Care programme was as a direct result of the commitment in *'Building on the Best, Choice, Responsiveness and Equity'*. This commitment was to take forward training programmes so that all adult patients, irrespective of diagnosis, nearing the end of life would have access to high quality palliative care and be able to live and die in the place of their choice. A total of £12m over three years has been allocated to support the programme which aims to skill up staff for whom end of life care is only part of their workload, ensuring that wherever a person dies they receive good care. The focus of the programme is on the dissemination of three key tools: the Gold Standards Framework, the Liverpool Care Pathway and the Preferred Place of Care, which were recommended in *Improving Supportive and Palliative Care for Adults with Cancer* (National Institute for Clinical Excellence, 2004).
- *Facts and Figures on Care Homes* – A paper which aims to pull together existing information on End of Life Care in care homes from the End of Life Care Programme website
<http://eolc.cbcl.co.uk/eolc/facpacandotherdocs/facts%20and%20figures10.doc/view?searchterm=facts>

Joined-Up Care

A key principle in the care of frail older people is that of timely intervention through joined-up care. This involves the early identification of problems and treatment to prevent a crisis and rapid response to a crisis when it occurs to quickly restore health, independence and well-being. Timely intervention not only improves outcomes for older people but also reduces longer term costs of care, by reducing the need for support by families, hospital bed use and the need for intensive long-term care services.

Care systems are being strengthened for people with stroke, falls, dementia and with multiple conditions to improve prevention, treatment, rehabilitation and care. Good long-term conditions management is underpinned by a holistic assessment of needs, when older people come into contact with the care system. In crisis older people often develop falls or confusion. Emergency care is being redesigned to respond to these needs.

These developments are making an important contribution to system reform in the National Health Service and in Social Care. If system reforms are not fit to meet the needs of frail older people, they will not succeed.

Programme 3: Stroke Services



Significant progress has been made in improving stroke services since the publication of the NSF where Standard 5 described a service model for stroke and transient ischaemic attacks (TIA). This includes work on prevention, treatment, rehabilitation and long-term management. Now all hospitals that care for stroke patients have a specialised stroke service. A survey by the Healthcare Commission published in 2005 showed that 64% of

respondents reported that they stayed on a stroke unit for most of their stay compared to 27% reported in 2001 National Sentinel Stroke Audit.

The quality requirements set out in the Long Term Conditions NSF will support the drive to improve the long term care stroke patients receive. The Department of Health is also funding a new £20 million research network to improve our understanding of what works and promote further service improvements.

However, there remain issues about capacity and responsiveness because not everybody who would benefit from specialist services is receiving them, and new treatments and evidence have increased the importance of treating stroke and TIA as medical emergencies.

Work has begun on an 18 month programme to develop a new national strategy for stroke. This is being taken forward by expert project groups which will focus on 6 key areas.

Aims:

1. To raise public awareness about stroke symptoms and risk factors, and to improve primary and secondary prevention of those vascular risk factors.
2. To ensure that people who suffer TIAs have rapid access to high quality, appropriate diagnostic and treatment services.
3. To accelerate the emergency response to stroke, including through improved access to CT scanning.
4. To recommend the models of service provision and ways of working in the acute phase of stroke, appropriate to delivering new treatments.
5. To support stroke survivors as they transfer from hospital to home and to provide the long-term support services needed after stroke.

6. To ensure that the workforce is developed, in terms of numbers and skills, to enable the implementation of the strategy.

Further resources

- Further information on the development of the new national stroke strategy and resources relating to improving stroke services are available at www.dh.gov.uk/stroke . The Department of Health stroke team can be contacted at MB-Stroke-Ideas@dh.gsi.gov.uk
- Act FAST. The Stroke Association have funded research into FAST – the Face Arm Speech Test – which is being used by paramedics to diagnose stroke prior to a person being admitted to hospital.

FAST requires an assessment of three specific symptoms of stroke:

Facial weakness – can the person smile? Has their mouth or eye drooped?

Arm weakness – can the person raise both arms?

Speech problems – can the person speak clearly and understand what you say?

Test all three symptoms

If the person has failed any one of these tests you should call 999 to ensure prompt and early treatment and reduce the chance of death or long-term disabilities. More information on the Stroke Association's 'Stroke is a Medical Emergency' campaign can be found at <http://www.stroke.org.uk/campaigns>

Programme 4: Falls and Bone Health



The development of integrated falls services was a key objective in the NSF for Older People and a response to an evidence-base which emerged in the mid-1990s about the focus and value of falls services to help prevent and manage falls and their consequences.

A national audit of falls services for older people undertaken by the Royal College of Physicians (January 2006) showed 74%

of Trusts having part of a coordinated, integrated, multi-agency service for falls. However, there are areas of hospital services, such as emergency departments and fracture units, which particularly lack fully organised services while the audit also shows services for bone health lagging behind those for falls.

NICE guidelines on falls services and on drug treatments for bone health have been published and are in line with the service models in the NSF.

There are five components of an integrated falls service. The development of each component sets the agenda and priorities for the next phase of investment and reform.

Aims:

1. To extend council, PCT and voluntary sector initiatives to improve exercise, balance, medicines management, environment and footwear for older people to reduce falls risk.
2. To improve emergency response to falls with a key role for emergency care practitioners to assess people who have fallen prior to transfer to an emergency department and mobilize intermediate care services where a need for hospital assessment is not required.
3. Every economy to have access to a falls assessment service for people with recurrent falls, or one fall with serious consequences.
4. To increase capacity in osteoporosis services in DXA scanning for bone density as a guide to treatment. In 2005-06 £3 million has been allocated from a centrally held revenue budget for purchasing of additional scans (mainly from independent sector (IS) providers) in SHAs where there are the most pressing short-falls. Capital provision of £17m has been made in 2006/7 and 2007/8 to improve NHS capacity through investment in new DXA scanning equipment.
5. To improve rehabilitation services for people who have lost functional ability or confidence after a fall.

Further resources

- Further information on the Royal College of Physicians falls audit can be found at <http://www.rcplondon.ac.uk/college/ceeu/fbhop>
- Further information on falls service development can be found on the DH website including documents on making the case for falls and fracture prevention and a guide to commissioning good services for falls prevention (www.dh.gov.uk)
- The Healthy Communities Collaborative
The Healthy Communities Collaborative was set up to test out whether engaging residents in a deprived community in improving health outcomes in a particular topic would also assist in raising social capital giving them the confidence to move onto other issues.

The first topic chosen was reducing falls in older people. The reason was that once every 5 hours someone over the age of 65 dies directly or indirectly as a result of a fall and 40% never go back to independent living. The health and social care cost of hip fractures in England is £1.7billion.

More information can be found at www.improve.nhs.uk under topics and inequalities.

Programme 5: Mental Health in Old Age



Reviews of progress for the NSFs for Mental Health and Older People have highlighted challenges in the delivery of mental health services for older adults. A new Department of Health programme board for older adult mental health services has been set up to coordinate a response to meet these challenges.

National Directors for Mental Health, Louis Appleby, and Older People, Ian Philp, outlined their vision for older people's mental health services in *Securing better mental health for older adults*, published in July 2005. This was followed by a new OPMH service development guide, *Everybody's Business*, in November 2005.

Everybody's Business builds on the service models outlined in the National Service Framework for Older People and the principles promoted in *Securing better mental health for older adults*, in describing the foundations and key elements of a comprehensive older adult's mental health service. The Healthcare Commission and Commission for Social Care Inspection have identified *Everybody's Business* as a benchmark for mental health services and will use it to aid their inspection processes.

Aims:

1. To ensure age equality in the development of mental health care for adults of all ages, with access to services on the basis of need, not age. This will also include the integration of underpinning programmes of work, such as support for service improvement, workforce development, guidelines development, research and development, information systems, performance management, and inspection and audit, across the younger and older adult mental health services.
2. To improve the skills and competencies of staff to enhance detection and management of mental illness in all non-specialist settings, so that wherever people are, they are not discriminated against, and have their mental health needs managed well.
3. To secure comprehensive specialist mental health services for older adults, with a particular emphasis on community mental health teams, memory assessment clinics, and liaison services.
4. To promote mental health as part of active ageing.

Further Resources

- *Securing better mental health for older adults* (DH, 2005) (Professor Ian Philp and Professor Louis Appleby).
This document marks the start of a new initiative to combine forces across mental health and older people's services to ensure that older people with mental illness do not miss out on the improved services that younger adults or those without mental illness have seen. It provides a vision for how all mainstream health and social care services, with the support of specialist services, should work together to secure better mental health for older adults, and describes how the Department of Health is aiming to help deliver this. www.dh.gov.uk
- *Everybody's Business. Integrated mental health services for older adults: a service development guide.* (CSIP, 2005)
Everybody Business was launched in November 2005 to improve health and social care practice at the front line. Our message is clear. Older people's mental health cuts across health and social care, physical and mental health and mainstream and specialist services.

The new service development guide is committed to:

- improving people's quality of life
- meeting complex needs in a co-ordinated way
- providing a person-centred approach
- promoting age equality

<http://www.olderpeoplesmentalhealth.csip.org.uk/everybodysbusiness>

- The Social Exclusion Unit report on older people (SEU, 2005) highlighted the links between a lack of social activity and inclusion and mental ill-health, especially depression, in older people. Lack of social participation emerged as a key factor in influencing a sense of isolation. Health promotion should be seen as a continuum that includes maintaining good mental health, preventing problems, care and treatment, and recovery.

The Partnerships for Older People projects (POPPs) will demonstrate ways of developing lower level interventions that can prevent crises, including emergency admissions to acute care and early admission to care homes. Seven of the projects have a specific focus on OPMH – Bradford, Camden, Leeds, Luton, East Sussex, Norfolk and Southwark. For further information see <http://www.changeagentteam.org.uk/index.cfm?pid=267>.

Mental health promotion is vital at all stages of the life course. Other references which seek to highlight the issue and offer suggestions for action are:

NIMHE, 2005. *Making it possible: improving mental health and well-being in England* (pp24-25) www.nimhe.csip.org.uk

Mental Health Foundation and Age Concern England. *Inquiry into mental health and well-being in later life*. www.mhilli.org/inquiry/index.html

SEU, 2005. *Excluded older people*: SEU interim report. www.socialexclusion.gov.uk/downloaddoc.asp?id=710

Programme 6: Complex Needs



Many older people have one or more long-term condition and have difficulty in maintaining their independence, well-being and social participation. This creates challenges for practitioners, commissioners and service providers to develop integrated services which help service users maintain their independence, well-being and social participation, as well as working in partnership with family and other

informal carers, who may have needs in their own right.

A wide range of practitioners are involved in the care of people with complex needs. Some are working in well established ways such as acute hospital old age specialists, old age mental health teams, community nurses and social work care managers. Others are working in new ways, such as therapists, nurses and care assistants working in intermediate care settings or pharmacists undertaking medicines reviews for people on multiple medications. There are also new professional groups emerging, including community matrons and practitioners with special interests in older people.

There needs to be effective coordination of the work of these practitioners and the organisations involved across traditional service and team boundaries. Some intermediate care services provide excellent examples of integrated care provision. A national project involving key stakeholders has identified the key challenges for implementation:

Aims:

1. To achieve better coordination of care for people with complex needs.
2. To strengthen commissioning arrangements by the NHS and Councils for people with complex needs.
3. To develop managed networks for older people with complex needs.
4. To build on successful developments in intermediate care services.

Further Resource

- *Report on the Complex Care Network Project* (DH, 2005) – Annex 1
This paper presents the outputs from a pilot project that aimed to explore and articulate the issue of service response for older people with complex needs and develop a unifying definition for this group of service users.

- *Our health, our care, our say* White Paper (DH, 2006) (Gateway ref 2006)
The White Paper (page 116) offers some key points on the care of people with complex needs:
 - The importance of case managers who can organise and coordinate services from a wide source of providers, the huge benefit that will bring and the commitment to 3000 community matrons who, along with social workers and occupational therapists, will play a major role in this work
 - It encourages the creation of multi-disciplinary networks and teams at PCT and local authority level, using a Common Assessment Framework, involving social services, housing, NHS primary, voluntary, community and secondary care services, working alongside existing community palliative care teams
 - By 2008 we would expect all PCTs and local authorities to have established joint health and social care managed networks and/or teams to support those people with long term conditions who have the most complex needs
 - The recognition that people with complex needs require a single point of contact to mobilise support if there is an unexpected change in their needs or a failure in agreed service provision

The White Paper in full can be found at www.dh.gov.uk

Programme 7: Urgent Care



Older people are not only heavy users of urgent care services, they are also more likely to experience longer waits in emergency departments, to be admitted to hospital and to have more prolonged length of stay once admitted. A significant proportion of those admitted could benefit from alternatives to admission. Whether admitted, or provided with alternatives to admission, early access, review or management by

specialist multi-disciplinary old age-related teams will improve outcomes for patients and be an efficient use of resources.

Aims:

1. To redesign urgent care response to falls, mobilising intermediate care services and avoiding inappropriate attendance in emergency departments or hospital admission where there is no life-threatening illness or need for surgery, with early assessment and management by a multi-disciplinary falls service.

2. To redesign urgent care response to people with acute confusion (delirium) on a background of dementia or arising de novo in the context of medical crises, with early assessment by old-age specialists to investigate and treat underlying medical problems and with subsequent review of mental health needs.
3. To redesign urgent care response for stroke and transient ischaemic attack as part of the work to develop a new national stroke strategy.

Further resources

- *8 quick wins for emergency reform and the care of older people* (Gateway Ref 5018). Older people are less likely than younger adults to visit the Emergency Department but, when they do they tend to be sicker and have more complex needs. As a result, while the work to deliver the 4 hour target has had more impact for older people than for any other age group in reducing the time spent in the Emergency Department, older people are still more likely than younger adults to experience a long stay

This document highlights a few areas where immediate action may help. These ‘tips’ focus on specific actions that can be taken to improve outcomes and reduce the incidence of emergency events.

www.dh.gov.uk

- *Key Principles for emergency response pathway for people with falls and/or delirium (confusion) – Annex 2*

Programme 8: Care Records



Introducing a single process for assessing the health and social care needs of older people, developing personal care plans and sharing this information as people move through the care system are key objectives of the National Service Framework for Older People. The Single Assessment Process (SAP) underpins much of the reforms towards delivering personalised care, joined-up services, timely response to identified needs and the promotion of health and active life.

There has been an extensive engagement of health and social care practitioners and managers in local communities to agree local solutions to meeting the SAP requirements. However, to ensure that the potential benefits of a Single Assessment Process are maximised information technology to support efficient and secure sharing of information across health and social care communities needs to be developed further. As stated in the White Paper *Our health, our care, our say* we will develop a Common Assessment Framework by building on the Single Assessment Process in order to deliver the benefits of a holistic needs assessment for all adults with long-term conditions.

Aims:

1. To simplify and extend the SAP approach to all adults with long-term conditions.
2. To fit SAP implementation into the wider work across local and national government in developing personalised and integrated record systems.
3. To ensure that comprehensive assessment is undertaken prior to long-term or residential nursing home care.

Further Resource

- *Our health, our care, our say* White Paper (DH, 2006) (Gateway ref 2006)
The White Paper (pages 114/115) sets out the direction of travel for building on the Single Assessment Process, developed for older people, and extending it in the form of a Common Assessment Framework to all adults with a long-term condition.

Integrating health and social care information is an important part of the NHS Connecting for Health strategy. Ultimately, everyone who requires and wants one has a personal health and social care record.

By 2008 we would expect everyone with both long-term health and social care needs to have an integrated care plan if they want one. By 2010 we would expect everyone with a long-term condition to be offered a care plan.

The White Paper in full can be found at <http://www.dh.gov.uk>

Healthy Ageing

Most older people want to remain healthy and live independent lives for as long as possible. With a high uptake of health promotion activities amongst older people and early returns for improved health, independence and well-being, it makes economic sense to invest in systems which promote health in old age.

We intend to provide more opportunities for older people to increase their levels of physical, mental and social activities. A broad range of organisations from the independent sector, the NHS and Local Government are involved in this work.

We will provide extra support for socially excluded groups, including those with mobility problems, sensory or cognitive impairments, who are socially isolated, living in poverty or with specific needs arising from race or culture, so that these groups also have the opportunity to enjoy active ageing.

Most importantly, older people themselves have the potential to contribute more to the lives of their families and their local communities and in so doing improve their own health, independence and well-being.

Programme 9: Healthy Ageing



Promoting healthy ageing is a strong theme in the National Service Framework for Older People, and a top priority of many organisations which represent older people. Contrary to popular belief, health promotion services are popular amongst older people, with a strong evidence base for effectiveness in producing good health outcomes and reducing pressure on services and families by reducing impairments and disabilities.

Activities such as exercise classes and dancing, promote not only health and independence, but also increase social interaction leading to improved emotional well-being.

Health impairments can reduce older people's opportunities to enjoy active lives and social exclusion can reduce older people's to health and healthcare.

Our healthy ageing programme is the vehicle for delivering the older people's component of the delivery of the White Paper *Choosing health* and will be a key component in the delivery of the cross-government strategy for older people described in *Opportunity Age*.

Aims:

1. To improve physical fitness through encouraging and communicating the benefits of moderate regular exercise for older people.
2. To overcome barriers to active life for older people through giving attention to equipment, foot-care, oral health, continence care, low-vision and hearing services.
3. To improve access to health care and health promotion services for older people who are socially isolated, living in poverty, have mental health problems and those from black and minority ethnic groups, and protect vulnerable older people from cold and heat-related illness.
4. To extend healthy active life expectancy through disease prevention and modifying health behaviour through life checks and social marketing techniques.

Further Resources

- Choosing better oral health (DH, 2005) (Gateway Ref. 4790) is the Government's Oral Health Action Plan. It includes specific reference to older people's oral health and is available at www.dh.gov.uk
- For examples of national initiatives please refer to the POPP webpage on the DH website
- The *Choosing health* White Paper (Gateway ref 4135) sets out the key principles for supporting the public to make healthier and more informed choices in regards to their health. The Physical Activity Action Plan emphasises the importance of regular activity for older people, not only for help in preventing conditions such as diabetes and cardiovascular disease, but also for the maintenance of health, independence, and well-being. Local communities are at the centre of the Government's plans to enable older people to make healthy choices and more information on local area agreements can be found in both the White Paper and the Physical Activity Plan.

The *Choosing health* White Paper can be found here: www.dh.gov.uk

- The Department for Work and Pension's *Opportunity Age – Opportunity and security throughout life* can be found here http://www.dwp.gov.uk/opportunity_age/
- The Social Exclusion Unit's Report *A Sure Start to Later Life – Ending Inequalities for Older People* (Social Exclusion Unit, Office of the Deputy Prime Minister, 2006) can be found at www.socialexclusion.gov.uk
- Heatwave Plan
The heatwave in Northern Europe in 2003 killed 27000 people. Most of them were older people. Since 2004 England has a Heatwave Plan. It sets out what we need to do BEFORE, as well as when, a heatwave occurs, if we are to protect our health, and that of vulnerable people, especially those in longterm care and residential homes. The plan and its accompanying advice sheets can be found at www.dh.gov.uk
- Keep Warm Keep Well Campaign
As we grow older, cold weather becomes increasingly dangerous. Thousands die unnecessarily every winter, not from hypothermia, which is rare, but from heart attacks, strokes and chest disease. As a country, and compared with others, such as Germany or Norway, we tend to keep our houses cooler, and wear less when we go outside. The Keep Warm Keep Well campaign runs every winter in England. It provides practical advice and signposts to where to go for help, through leaflets, broadcast media, a helpline and a website (www.dh.gov.uk). It places much emphasis on the importance of flu immunisation.

Programme 10: Independence, Well-being and Choice



The promotion of health, independence and well-being amongst older people is at the heart of the Green Paper *Independence, well-being and choice*.

A number of national pathfinding projects have been initiated including:

- The Innovations Forum and Partnerships for Older People Projects
- Local government Shared Priority learning sets for the promotion of well-being of older people
- Developing an approach to telecare investment to support the promotion of independence of older people through assistive technologies

- Individual budgets for users of social care
- Self-assessment pilots

Aims:

1. To increase the use of assistive technology to promote independence.
2. To strengthen leadership and partnership between councils, the local NHS and the voluntary sectors in the promotion of the well-being of older people and their families.
3. To increase the use of direct payments and individual budgets to increase choice for older people and their families in social care.
4. To increase the uptake of assessment and response to carers' needs.

Further Resources

Briefing on the following areas can be found on the DH website:

- Partnerships for Older People Projects – the aim of the project is to test and evaluate innovative approaches that sustain prevention work in order to improve outcomes for older people www.dh.gov.uk
- Telecare offers the promise of enabling thousands of older people to live independently, in control and with dignity for longer. This document, *Building Telecare in England*, provides local authorities and their partners with guidance in developing telecare services for their communities www.dh.gov.uk
- The Innovations Forum – The Innovation Forum was created in 2003 to promote dialogue between central and local government, and its partners, on new ways of working to deliver better services to local communities. Early on in its existence, Innovation Forum members agreed that they wanted to explore innovation and push at the current boundaries of service provision via projects in specific thematic areas that presented challenges to existing public service provision. One of the centres on reducing hospital admissions for older people and more information can be found on the IDeA website <http://www.idea-knowledge.gov.uk/idk/core/page.do?pageld=77735>
- Background to Local Area Agreements and Local Public Service Agreements www.dh.gov.uk

- Direct Payments – Direct payments (cash in lieu of social services) for adults of working age were introduced in April 1997, through the *Community Care (Direct Payments) Act 1996*. They were extended to older disabled people in 2000. The *Health and Social Care Act 2001* paved the way for a variety of changes to the way in which direct payments schemes operate, and regulations came into force in April 2003 require councils to offer direct payments to people using community care services who can choose to have them.

The Direct Payments Development Fund – £3m each year over three years – supports voluntary and community organisations in partnership with their local councils to build up the support services we have learnt are fundamental to the success of direct payments. It will not only increase take up in those areas that have received funding, but also provide valuable lessons for the future that all councils can learn from.

Detailed briefing can be found at: www.dh.gov.uk

- Individual budgets pilots – An Individual Budget would be designed to provide individuals who currently receive services greater choice and control over their support arrangements. The government is committed to piloting individual budgets with a view to rolling them out nationally should they prove successful. Detailed information can be found at www.dh.gov.uk

Support for Implementation

There are a range of mechanisms which will help to ensure progress against the key aims and objectives of dignity in care, joined up care and healthy ageing. These include the national priorities and planning framework, workforce modernisation, national guidelines development, investment in new technologies, and research and development.

In addition, five key implementation levers are outlined in more detail below.

Leadership

For each of the ten priorities, we will be working with leaders of advocacy and professional organisations. Their involvement reflects a shared vision and commitment to improving the health and well-being of older people. In many of the priority areas formal mechanisms for their involvement and consultation have been established.

Regulation and Inspection

The Healthcare Commission, Commission for Social Care Inspection and the Audit Commission have published a joint review of Older People's Services and are strengthening and aligning their inspection regimes to drive improvements in key areas of partnership working, falls, mental health and medicines management and dignity in care. In addition, the Audit Commission's Comprehensive Performance Assessment of councils now includes a strand on older people's independence and well-being. For the first time councils are now being assessed on how well they are working with partners, and with older people, to improve quality of life.

Public Service Agreement (PSA) Targets

The national priorities for the NHS and social care are based on the Department of Health's Public Service Agreement (PSA) Targets. The targets cover four broad priority areas: health and well-being of the population, long-term conditions, access to services, and patient/user experience.

In each of the areas there is a strong connection to one or more of the PSA Targets. For example, Dignity in Care is supported by the PSA Target on 'improving the patient/user experience' while the theme of Active Ageing is closely tied to the Target on 'Improving the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible'. A list of the relevant PSA Targets can be found in Annex 3 of the Next Steps Resource Document on the DH website (www.dh.gov.uk).

Commissioning

Members of the National Leadership Network have suggested ways in which commissioning might be developed for frail older people: strengthening multi-sectoral commissioning arrangements with greater use of pooled budgets, commissioning for integrated care networks, including care pathways for people with falls and confusion, and improving case-mix measurement for people with co-morbidities, to improve tariff systems.

Care Services Improvement Partnership (and other service improvement agencies)

The Care Services Improvement Partnership (CSIP) has been created to support service improvement and development in health and social care across a range of services which include older people, children and learning disability.

CSIP is strongly supportive of our plans to improve the health and well-being of older people and are already involved in many of the areas. For example in Dignity in Care it is supporting the Department of Health funded Standard 4 transformational projects for acute hospital care, in Emergency Response it is working with service commissioners in developing a whole systems approach and commissioning framework to ensure the needs of older people are met in an emergency, and in Mental Health, it is building on the review of inpatient services which the NHS was supported to undertake as outlined in *Moving on: key learning from Rowan Ward*.

CSIP will continue to work with us as our plans develop, offering support and advice to local health and social care systems on request.

Annex 1

Improving Care for Older People with Complex Needs Report from the National Director for Older People

Executive Summary

Aims: To bring greater clarity to defining the client group and appropriate service response for older people with complex needs

Methods: A modified soft systems methodology was used which consisted of three components:

- an exploratory workshop designed to identify the opportunities and barriers associated with implementing and embedding policies designed to support people with complex needs
- distilling the learning from teams of professionals, volunteers, carers and users based in three Primary Care Trust (PCT) areas across England as they explored these issues in more detail
- the establishment of a national reference group that considered, shaped and subsequently ratified findings

Results:

1 Proposed definition of:

(a) **client group:** typically, but not exclusively, older adults, with one or more multiple long term conditions, who have challenges in maintaining their independence, well-being and social participation

(b) **service response:** a person-centred approach which integrates care provision of multiple providers spanning health and social care in partnership with family and other informal carers

2 Recommendations

a) Assessing needs

- Users expectations need to be clearly identified with honest negotiations about how and how far these can be met, given service and resource availability.

- There is a need to ensure that up-to-date information about relevant services for people with complex care needs (including those provided by the voluntary sector) is readily available to health and social care practitioners. This information should also be accessible to carers and service users, with advice being given about how clients can access these services.
- b) Coordinating Care
- Where needs are complex, it is essential to identify a skilled individual who can help prioritise, organise and coordinate services from a wide source of providers with the professional background of the care coordinator determined by the primary needs of the service user.
 - Consideration should be given to appointing deputy care coordinators who can provide a complementary perspective, facilitate access to services and ensure cover for users who are offered a single point of contact for support.
 - Service users with complex care needs require a single point of contact to mobilise support if there is an unexpected change in their needs or a failure in agreed service provision. Further work needs to be undertaken to establish how this can be achieved on a 24/7 basis by, for example, linking care management with out-of-hours services
- c) Information Systems
- A shared health and social care information system is an essential requirement for effective care coordination
 - A personal care plan should be developed for all adults with complex needs, which follows the person, while moving through the care system.
- d) Integrated commissioning
- There needs to be better strategic commissioning of care for adults with complex needs, involving the NHS and local government.
 - Closer to the service user, effective arrangements need to be in place to align NHS gatekeeping and practice-based commissioning with social care case management and use of personalised budgets and direct payments.
- e) New organisational structures
- A variety of structures are emerging. Some support “horizontal” integration of services, such as Care Trusts which provide health, social care and, in some cases, wider services such as housing. Others support “vertical” integration, such as the Kaiiser model of integrated hospital and community health care.
 - These new structural models need to be evaluated for their impact on the health and well-being of adults with complex needs.

- f) Managed networks
- Mechanisms need to be in place to support integrated provision by practitioners working in different organisations through the creation of managed networks.
 - Managed networks for adults with complex needs:
 - should have a strong base of horizontal integration, including NHS, social care, housing and other local government functions.
 - should ensure rapid access to specialist services.
 - need dedicated resource to be sustainable.
 - need to operate on a sufficiently large geographic scale to ensure the involvement of key players, including social services, housing and NHS primary, community and secondary care services.

Professor Ian Philp
National Director – Older People and Neurological Conditions

Cathy Green
Senior Civil Servant

Department of Health
30th June 2005

Updated following discussion with the National Reference Group
11th November 2005

Complex Care Networks Project

Introduction

“International research suggest that integration is most needed and works best when it focuses on a specifiable group of people with complex needs, and where the system is clear and readily understood by service users (and preferably designed with them as full partners).” – Integrated Care: a Guide, Integrated Care Network 1

Professionals and researchers across health and social care are beginning to apply a number of different labels to essentially the same cohort of individuals who are known to be potentially intensive consumers of services. Latterly, this group has become the target of major policy initiatives. New roles and service models have already been introduced to try and meet their needs more effectively. Often these have been provided in addition to more traditional approaches to care without adequate consideration being given to the redesign and organisational development necessary to achieve integration.

“People with Complex Care Needs” “The Frail Elderly” “Level 3 Patients”

“The NHS and Social Care Long Term Conditions Model is designed to be fully embedded into the way NHS and social care services deliver care to those with long term conditions. As a result, adopting the new approach will involve major organisational change.” – Supporting People with Long Term Conditions – An NHS and Social Care Model to support local innovation and integration ²

In the midst of this creative and emergent environment, challenges and issues are beginning to surface that need to be addressed if we are to sustain and build upon this intended transformation in service provision.

One of the key challenges is how we make the most of the professional expertise and resources currently available. This includes new professional roles (e.g. community matrons and community pharmacists), professionals working in very different ways (e.g. physiotherapists, occupational therapists and generic care workers working in intermediate care settings) and professionals working in more traditional ways that are perhaps undervalued (e.g. old age mental health teams, hospital based specialists in the care of older people, social workers and care managers).

“We need to ensure the services we deliver are flexible and responsive enough to meet the differing needs and wishes of individuals. We must build on what works and learn from the experience and knowledge of front-line staff” – Independence, Well-Being and Choice – Our Vision for the Future of Social Care for Adults in England ³

“To deliver these new models the NHS will need to innovate. This might mean a new type of professional within a more traditional practice – community matrons and other specialist primary care workers are examples – but with the blurring of professional boundaries, there is scope for more creativity” – Creating a Patient-led NHS – Delivering the NHS Improvement Plan ⁴

This paper presents the outputs from a pilot project that aimed to explore and articulate these issues and develop a unifying definition for this group of service users. The project was initiated and overseen by the National Clinical Director for Older People, Professor Ian Philp and comprised three major components:

- an exploratory workshop designed to identify the opportunities and barriers associated with implementing and embedding policies designed to support people with multiple complex needs;
- distilling the learning from teams of professionals, volunteers, carers and users based in three Primary Care Trust (PCT) and related social service areas across England as they explored these issues in more detail;
- the establishment of a national reference group that considered, shaped and subsequently ratified findings.

The report represents a snapshot; it documents the work at a point in time. Findings and recommendations should be considered alongside a plethora of other pilots and projects that are seeking to explore and capture learning in a similar field. Some of this work has been referenced, but timescales have prevented a comprehensive review of related activity.

Policy Context

This pilot has been conducted within a rich and fluid policy context. Key policy documents include *Independence, Well-Being and Choice – Our Vision for the Future of Social Care for Adults in England* ³, *The National Service Framework for Older People* ⁵, *Supporting People with Long Term Conditions – An NHS & Social Care Model to support local innovation and integration* ², *Supporting People with Long Term Conditions – Liberating the Talents of nurses who Care for People with Long Term Conditions* ⁶ and *The National Service Framework for Long-Term Conditions* ⁷. Collectively, these have provided a clear and cohesive vision for proactive, patient-centred, seamless care coordinated across the statutory, private and voluntary sectors. For those less familiar with some of the key texts, a summary of the content pertinent to this paper has been provided in Appendix 1.

Other Relevant Articles

In addition to this fertile policy arena, there are two other key documents that are worthy of consideration. The first is a review conducted by the Kings Fund of the published literature on case management for older people that examined the evidence base for its impact on hospital admissions, length of inpatient stay, use of emergency facilities, health care costs and patient's functional ability ⁸. The second, was an interim report produced by researchers at Manchester University, looking at early results from the Evercare pilots ⁹. Their findings are summarised in Appendix 2.

The Complex Care Pilot

Exploratory Workshop

In January 2005, representatives from the three sites – Sheffield North, Ashton, Leigh & Wigan and Tower Hamlets PCTs – came together to explore the issues associated with developing services for people with multiple complex needs consistent with the latest policy thinking. Sites were selected because of their enthusiasm, commitment and track record of working to develop innovative practice within this area. The issues identified at this event and later endorsed by the national reference group are summarised below:

Key Issues

1. Develop understanding of user needs and priorities through defining the client group, describing the client groups' needs and priorities, and ensuring equity and inclusivity across factors such as age, mental health, ethnicity, social isolation and income.
2. Develop better understanding of complementarity of professional roles and service contributions and how these should change through fostering a shared understanding of new and established roles, a better understanding of integration of multi-professional practice, encouraging radical challenge to a genuine user focus to national and local systems and assessing the impact on other professional groups
3. Develop better understanding of how best to coordinate care through shifting gate keeping and resource allocation to reflect user priorities, optimising use of direct payments/personalised budgets, developing shared information systems (SAP), and managing the knock-on effects on a wider range of services
4. Develop principles for professional governance in improving communications and negotiating skills, building relationships, understanding and trust amongst professionals, utilising the knowledge and skills framework, creating a mechanism for professional development, along with systems for quality assurance of and ensuring sustainability of change to professional practice
5. Develop principles for multi-agency organisational governance through establishing systems for identifying user needs and reflecting this in organisational development, how to better manage risk better in a user focussed service, embed these principles in commissioning and fit to new commissioning models, encourage flexibility of service response, fit to financial accountabilities and governance and ensure sustainability of organisational change.
6. Ensure good fit between long-term conditions management and intermediate care services.
7. Ensure good fit between long-term conditions management by the NHS (with its anticipatory care, disease-focused approach) with long-term support and care co-ordination by social services (with its compensatory, re-enablement and life-enhancing approach).

Values-Based Workshops

Each pilot site hosted a one-day workshop bringing together professionals working across health and social care, carers and representatives from the voluntary sector to explore the successes and shortfalls in current service provision. These events were facilitated by experts from the Sainsbury Centre for Mental Health (kim.woodbridge@scmh.org.uk) using a methodology that encourages participants to connect with work-related values, establishing common purpose across professional and organisational boundaries. The introduction of a case study reduces defensive behaviour. It had been adapted from the work of Woodbridge and Fulford (2004) 10. The approach helps to minimise institutional and role-limited thinking.

“I’m encouraged about today – I’m hearing lots of us saying I’m not bothered about my professional background – I care about the service” – workshop participant

“Experience shows that where there is a will to work jointly there is an ability to overcome barriers to improve outcomes. Where the will does not exist, formal structures are not enough” – Independence, Well-Being and Choice – Our Vision for the Future of Social Care for Adults in England 3

“The process to confirm values is important. Shared values are not achieved by stating them but by living them. They must be owned, understood and enacted at all levels of the service” – Creating a Patient-led NHS – Delivering the NHS Improvement Plan 4

The stated aims of the workshops were to:

- describe the client group’s perceived needs and priorities;
- develop a shared understanding of new roles (e.g. practitioners with a special interest, community matrons);
- consider the challenges to adopting a genuine user focus;
- improve communication, building relationships and integration of practice.

Not all these aims were realised on the day itself and work continues locally to explore some of these areas in more depth (see Appendix 3 for Local Action Plans).

Key Findings

Users

- we need to be asking “what do you want from me?”, not “what can I offer you from the following...?”

“I normally go in thinking “what can I do for you”, I’m reminded I need to go in saying “what do you want from me?”” – workshop participant

“you can be drawn into fitting people’s needs to the service rather than fitting the services to their needs” – community social worker

“treat people as human beings and as individuals, not just people to be processed” – Creating a Patient-led NHS – Delivering the NHS Improvement Plan ⁴

- it is better to be honest about what is possible than promise something and not deliver

“we have lost trust – both in terms of the clients trusting the professionals and trust amongst colleagues within a team” – workshop participant

“they don’t care what uniform they wear or what their title is, so long as they deliver the care they need” – Long-Term Conditions Pilot, Modernisation Agency ¹¹

- needs will change over time and packages of care need to be adjusted accordingly

“Analysis shows that identifying high risk patients may not be static; many will recover. Similarly, other high risk patients will emerge.” – Supporting People with Long Term Conditions – An NHS and Social Care Model to support local innovation and integration ²

Key Findings

Services

- the range of services provided for an individual with multiple complex needs is often limited by the awareness of the key worker of what is available locally. This raises issues of equity and choice

“There is potential to unlock resources already within the system and to make more use of wider community capacity and voluntary sector support to create a more diverse range of services than is currently on offer, and in so doing better meet the needs of individuals” – Independence, Well-Being and Choice – Our Vision for the Future of Social Care for Adults in England ³

“One of the identified inhibitors of trust between secondary and primary care clinicians is individual variation in care management. This can be overcome by the application of decision support tools and locally developed and agreed care protocols and guidelines. These are not intended as inhibitors to positive features such as personal style or of individual patient choice - but they are ways of eliminating ineffective and idiosyncratic practice and of delivering uniformly high standards of care, both of which build trust between groups of practitioners and between patients and practitioners.” – Clinicians, services and commissioning in chronic disease management in the NHS - the need for coordinated management programmes ¹²

- lack of availability of integrated and modern communication systems for front-line staff is seen as a significant barrier to more integrated working

“Co-location of staff is strongly associated with successful joint working, but the absence of shared IT is a common failing” – Integrated Care: a Guide, Integrated Care Network ¹

“Information, including clinical information, is the starting point from which innovation and change can flow” – Clinicians, services and commissioning in chronic disease management in the NHS – the need for coordinated management programmes ¹²

Key Findings

Existing and New Roles

- where needs are complex, it is essential to identify a skilled individual who can help prioritise, organise and coordinate services from a wide source of providers. They become the single point of access for the service user. The competencies required to perform this function and secure continued commitment across service providers to adhere to an agreed care plan should not be underestimated

“Skills for Health and the Institute for Skills, Learning and Innovation...are defining community matron competencies to inform training programmes” – Supporting People with Long Term Conditions – Liberating the Talents of nurses who Care for People with Long Term Conditions 6

“For people with complex needs, the challenge is not so much that of providing services, but ensuring a more coordinated response” – Independence, Well-Being and Choice – Our Vision for the Future of Social Care for Adults in England 3

“The community matron should act as a fixed point for the patient, taking clinical responsibility for their care and co-ordinating the contribution of the different professionals who can help, anticipate and deal with their problems before they lead to worsening health or well-being.” – Supporting People with Long Term Conditions – An NHS and Social Care Model to support local innovation and integration 2

“Some people with more complex needs requiring skilled multidisciplinary input from a number of different agencies will need an identified person who coordinates care. The job title of such people currently varies (eg a care coordinator, case manager or community matron). This role includes developing a comprehensive care plan involving a range of agencies and may involve arranging access to appropriate health and social care services. Ideally, services need to be commissioned from a pooled budget with the care plan acting as a ‘passport’ to services.” – The National Service Framework for Long-Term Conditions 7

Key Findings

Existing and New Roles

- ideally the professional background of the care coordinator should be determined by the primary needs of the service user. If these are predominantly for social care, a social worker or social care navigator should fulfil this role, if health-related, a community matron or other health professional. For a seamless service to be provided, the care coordinator should have a designated deputy to enable a continuous service, 24 hrs a day, 7 days a week. There are perceived benefits in assigning this function to a professional working in a different part of the service, e.g. health if the care coordinator is from social services and vice versa. This provides balance and is likely to help expand their joint knowledge base and facilitate access to local services not under the care coordinator's direct control.

“It is recognised that other professionals may also take on a case management role for this group of patients. However, where the clinical needs of these patients are high, we expect that community matrons will take on the case management role” – Supporting People with Long Term Conditions – An NHS and Social Care Model to support local innovation and integration ²

“Patients will demand more flexible services with greater use of evenings and weekends and different ways to access services. Staff will quickly need to offer more flexible responses while remaining within proper professional boundaries” – Creating a Patient-led NHS – Delivering the NHS Improvement Plan ⁴

- there is a poor level of knowledge about some of the ‘new roles’ (e.g. community matrons) and how these will effect the dynamic of existing teams. There are concerns that current roles are not being fully utilised, with a general lack of awareness about the generic and specialist skills that existing team members bring and what their unique contribution could be

“I’m going to go and look at the people resources we’ve already got - and start activating ‘inactive’ resources” – workshop participant

“We don’t need to reinvent all these roles but we do need to recognise them & bring them together” – Long-Term Conditions Pilot, Modernisation Agency ¹¹

- there is some concern that the appointment of community matrons will have an adverse effect of the availability of staff to deliver care packages

“Many areas have reported problems in providing complex care packages for people at home because of the serious difficulties in recruiting and retaining staff. This is not helped by competition between and within different sectors. There are opportunities here for collaborative working across health, social care and independent providers” – Changing Times – Improving Services for Older People: Report on the Work of the Health and Social Care Change Agent Team 2003/04 ¹³

Key Findings

Existing and New Roles

- Patient/service users as well as existing practitioners need to be prepared for the introduction of new roles
- District Nurses will already be caring for some patients with multiple complex needs. They can help in identifying those patients who meet the criteria for care management but are also likely to need support as they are expected to change their own practice to accommodate the introduction of community matrons

“Improving the care of very high intensity users will require more than introducing community matrons. It involves considerable organisational change to make sure that the wider systems support this model of care” – Supporting People with Long Term Conditions – Liberating the Talents of nurses who Care for People with Long Term Conditions 6

- Ideally, existing teams providing support for people with multiple complex needs will be involved in the fine-tuning of role descriptions for any new posts

“Introducing community matrons to case manage those with the greatest burden of disease means many people need to work differently and with new partners. This will only happen if all of those affected are involved in a true partnership and competing priorities harmonised around the needs of the patients” – Supporting People with Long Term Conditions – Liberating the Talents of nurses who Care for People with Long Term Conditions 6

Personal Development

- personal development and inter-organisational working could be enhanced if locality teams took more opportunity to review cases within a multi-professional, multi-perspective environment

“It is critical to build trust and good working relationships between all those involved in the various aspects of chronic disease management – be it determining the organisational culture and allocating community resources, or redesigning delivery systems” – Clinicians, services and commissioning in chronic disease management in the NHS – the need for coordinated management programmes 12

National Reference Group

The National Reference Group was set up to help deepen understanding about delivering care to people with multiple complex needs and create ownership and national leadership for new ways of working. Appendix 4 contains a list of its membership.

The Reference Group made the following proposals:

1 Definitions of Client Group and Service Response

The Group considered a number of definitions already being used to categorise this cohort of service users and attempted to capture key elements of these, whilst trying to avoid an overly health-dominated approach and a description that suggested passivity on the part of users.

- (a) Client Group: Typically, but not exclusively, older adults, with multiple long-term conditions, who have challenges in maintaining their independence, well-being and social participation.
- (b) Service Response: a person-centred approach which integrates care provision of multiple providers spanning health and social care in partnership with family and other informal carers.

2 Key Challenges

The Group identified key challenges for implementation, taking into account the lessons from the workshops about front-line experience, as well as their understanding of national policy and practice developments.

- a) Assessing needs
 - Users expectations need to be clearly identified with honest negotiations about how and how far these can be met, given service and resource availability.
 - There is a need to ensure that up-to-date information about relevant services for people with complex care needs (including those provided by the voluntary sector) is readily available to health and social care practitioners. Ideally, this information should also be accessible to carers and service users, with advice being given about how clients can access these services.
- b) Coordinating Care
 - Where needs are complex, it is essential to identify a skilled individual who can help prioritise, organise and coordinate services from a wide source of providers with the professional background of the care coordinator determined by the primary needs of the service user.

- Consideration should be given to appointing deputy care coordinators who can provide a complementary perspective, facilitate access to services and ensure cover for users who are offered a single point of contact for support.
 - Service users with complex care needs require a single point of contact to mobilise support if there is an unexpected change in their needs or a failure in agreed service provision. Further work needs to be undertaken to establish how this can be achieved on a 24/7 basis by, for example, linking care management with out-of-hours services.
- c) Information Systems
- A shared health and social care information system is an essential requirement for effective care coordination
 - A personal care plan should be developed for all adults with complex needs, which follows the person while moving through the care system.
- d) Integrated commissioning
- There needs to be better strategic commissioning of care for adults with complex needs, the NHS and local government.
 - Closer to the service user, effective arrangements need to be in place to align NHS gatekeeping and practice-based commissioning with social care case management and use of personalised budgets and direct payments.
- e) New organisational structures
- A variety of structures are emerging. Some support “horizontal” integration of services, such as Care Trusts which provide health, social care and, in some cases, wider services such as housing. Others support “vertical” integration, such as the Kaiiser model of integrated hospital and community health care.
 - These new structural models need to be evaluated for their impact on the health and well-being of adults with complex needs.
- f) Managed networks
- Mechanisms need to be in place to support integrated provision by practitioners working in different organisations through the creation of managed networks. (See Appendix 4 for definition)
 - Managed networks for adults with complex needs:
 - should have a strong base of horizontal integration, including NHS, social care, housing and other local government functions.
 - should ensure rapid access to specialist services.
 - need dedicated resource to be sustainable.
 - need to operate on a sufficiently large geographic scale to ensure the involvement of key players, including social services, housing and NHS primary, community and secondary care services.

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- External Reference Group

Thanks to the following individuals who contributed to discussions as members of the National Reference Group:

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- Local Workshops

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Appendix 1

Independence, Well-Being and Choice – Our Vision for the Future of Social Care for Adults in England ³ – 2005

This consultation document advocates moving to a proactive and preventative model of care where users and carers are put at the centre of service planning and delivery. It acknowledges they should be recognised as partners in assessing their own needs and choosing how those needs are met through a combination of statutory, voluntary or independent provision, probably facilitated by the expansion of direct payments. It encourages better signposting and information about services, new models of service provision and roles to enable this vision to be realised. It introduces a set of outcome measures by which the quality of social care can be assessed.

It goes on to acknowledge the need for better coordination and integration of services, particularly across health and social care. It proposes a balanced commissioning model to meet low-level through to multiple complex needs with greater utilisation of universal and community services. Whilst recognising the significant leadership role entrusted to Directors of Adult Social Services, it suggests this can only be achieved through health, social care, voluntary and statutory organisations working together to take forward a community-wide approach. It seeks to encourage and empower the workforce to be more innovative and support people to make their own choices, recognising that more needs to be done to improved workforce planning.

National Service Framework for Older People ⁵ – 2001

This paper sets out a ten-year programme for action and reform to deliver higher quality services for older people. The following expectations are introduced:

- the identification and elimination of age discrimination in health and social care;
- the importance of patient centred care – delivering services to meet individual needs;
- the establishment of integrated continence and community equipment services;
- the establishment of intermediary care services;
- improvements in the organisation of acute hospital-based care;
- prevention of strokes and improvements in stroke services;
- prevention of and appropriate treatment for people who fall;

- provision of a comprehensive mental health service for older people;
- the promotion of good health in old age.

Supporting People with Long Term Conditions – An NHS and Social Care Model to support local innovation and integration 2 – 2005

This paper emphasises the scale of the challenge, outlining the numbers of people with Long Term Conditions and the impact their needs have on the health and social care system. It expresses a desire to move away from what is seen as reactive, episodic and unplanned care to personalised services organised around an individual's needs, provided in the least intensive setting possible, coordinated, systematic and anticipatory.

The document advocates:

- case management for those with complex long term conditions and high intensity needs;
- disease-specific care provided by multi-disciplinary teams based in primary care and the community;
- support for self care and self management;
- the need to identify very high prospective users;
- the introduction of 3000 community matrons to provide a case management function;
- patient empowerment;
- the use of data to identify and monitor patients.

It concludes: “Adopting the new approach will involve major organisational change. Primary Care Trusts, supported by Strategic Health Authorities and working in partnership with Local Authorities will need to develop robust improvement plans for taking this forward, with an initial focus on implementing the case management approach to care.”

Supporting People with Long Term Conditions – Liberating the talents of nurses who care for people with long term conditions 6 – 2005

The publication focuses on patients with the most complex needs and the role of the community matron, drawing on the experiences of those places already delivering services in new ways. In addition, it:

- presents the failings of the current system – uncoordinated and reactive resulting in multiple episodes of unscheduled acute care;
- describes the Kaiser model including the place that case management has in supporting people at Level 3 of the triangle;
- defines the role of the community matron and provides a definition for the types of patients they would be expected to support;
- describes the principles and components of case management;
- discusses workforce development and training needs, exploring how these posts can be filled without undermining staffing levels in other parts of the care system

The National Service Framework for Long-Term Conditions 7 – 2005

This paper sets out a new strategic model for the management of long term conditions through self care, disease management and case management. Although this National Service Framework focuses on people with neurological conditions, much of the guidance it offers can be applied to anyone living with a long-term condition. It builds on “Supporting People with Long Term Conditions – An NHS and Social Care Model to support local innovation and integration 2.”

‘Quality requirements’ set out a clear vision of how to improve the quality, consistency and responsiveness of services and personalised care. They include:

- providing information and coordinated person-centred care – the need for a holistic, integrated, interdisciplinary approach to care planning, review and service delivery involving a range of agencies;
- improving access to neurological services for diagnosis and treatment, ensuring conditions are identified and referred to appropriate specialist healthcare services as quickly and with as few intermediate steps as possible;
- improving care of people experiencing a neurological or neurosurgical emergency;

- improving access to rehabilitation services so that people disabled as a result of a neurological condition can achieve and maintain the greatest possible level of independence and social inclusion;
- providing flexible services and packages of care to help people live as independently as possible according to their own choices;
- improving palliative care services for people in the later stages of their illness;
- supporting families and carers;
- providing appropriate neurological care in hospital and other health and social care settings.

Creating a Patient-led NHS – Delivering the NHS Improvement Plan 4 – 2005

This document sets out the Government's ambition for the next few years – to change the whole system so that there is more choice, more personalised care, real empowerment of people to improve their health – indeed a fundamental change in the relationships with patients and the public. The vision is to move from a service that does things to and for its patients to one which is patient led, where the service works with patients to support them with their health needs.

The paper introduces the National Leadership Network for Health and Social Care that has been established to play a key role in taking forward the work, collecting feedback and shaping the way change is implemented.

There are six major themes addressed:

- establishing a truly patient-led NHS – providing patients with information and greater choice, creating stronger safeguards and standards and finding mechanisms to understand more about patients requirements and expectations;
- developing new service models – giving patients more choice and control, creating integrated care networks for emergency, urgent and specialist care and ensuring that everyone contributes to health promotion, protection and improvement activity;
- expanding the range of services commissioned on behalf of patients and providing them with greater choice;
- streamlining commissioning;

- encouraging a greater emphasis on prevention, health promotion and patient empowerment;
- organising the system, including incentives, organisational structures and development and underpinning infrastructures (e.g. IT and workforce development) to enable the realisation of this vision.

Appendix 2

Case-Managing Long-term Conditions – What Impact does it have in the Treatment of Older People? ⁸ – 2004

Of the studies included in this review, 14 were randomised control trials, three were non-*randomised* control trials and the remaining two were before-and-after studies. The goals and design of the case-management interventions varied between studies. The paper's findings were as follows:

- there is currently weak evidence for the effectiveness of case management in preventing admissions to acute care in elderly patients;
- there is no consistent effect on the use of emergency departments following case management;
- most studies show decreases in hospital-bed days associated with case management;
- in four studies, case management improved functional status or prevented deterioration. In no study did case management have an adverse effect on functional status;
- it is not possible to directly compare costs

The researchers concluded that:

- there is some limited evidence that case management for older people could reduce use of health services. The evidence that exists is drawn from studies of different populations of older people living in different settings and countries;
- many different models of case management exist and the review does not find evidence for the superiority of any particular model. American models of case management, around which current policy on case management has evolved in England, differ in context from the target populations of current NHS policy;
- in the absence of evidence for any specific model of case management, PCTs should clarify the needs that they were trying to address and then consider how to organise services in order to address these needs. This may be possible by adapting existing services or may require the development of new systems and services;

- evidence for the cost-effectiveness of case management is limited. Further evaluation is needed to establish whether the costs of providing case management are offset by savings from reduced service utilisation;
- PCTs should be given flexibility to develop their own arrangements to improve care for patients with long-term conditions, taking into account existing local services and local needs. Case management is unlikely to provide an ‘off-the-shelf’ solution to achieving the required reductions in emergency admissions;
- primary and community care services in the NHS are more comprehensive than in other countries. Elements of case management may already be in place in existing NHS services;
- little has been written about how case management arrangements should link with other parts of health and social care.

Evercare Evaluation Interim Report: Implications for supporting people with long term conditions in the NHS 9 – 2005

The interim findings of this independent evaluation of the ‘Evercare’ model (nurse-led assessment and intensive case management for frail older people), indicate the following:

- the approach is successful in identifying vulnerable older people, giving preventative health care, responding promptly to deteriorations in health and providing the potential to organise care around patients’ needs.
- the techniques and tools provided by United Healthcare Group to assist case management are not necessarily the only approach considered to be of benefit.
- there is only anecdotal evidence that the programme has reduced hospital admissions
- admission rates for this group of patients are likely to decline year-on-year irrespective of changes in service models introduced to provide intensive case management

Appendix 3

North Sheffield Primary Care Trust

Complex Care Project

	Target Date	Progress
Communication:		
Write up first workshop	June 05	complete
Develop road shows	July 05	
Widen engagement (?include housing etc)	Aug 05	
Prepare “clients” for new roles (Talk to carer groups/Lunch clubs)	Oct 05	
Prepare “professionals” for new roles (primary/secondary care)	July 05	
Workforce:		
Early identification of problems before crisis develops: <ul style="list-style-type: none"> • Explore casefinding systems • Develop rapid response 	Aug 05	
Specialised workforce to meet needs	Nov 05	
Support for new roles: Training & Development/ Clinical governance/Peer support/ Change Management	Dec 05 Dec 05	1 “Values Based Workshops” completed April 3 further to be delivered July
Information:		
Enhance shared information	Dec 05	
Population/community data becoming more accessible but often not accessed/ used to develop/provide services.	Dec 05	

Update: Progress from Complex Care Workshop – Wigan

On-going Activity from Workshop	Progress
1. Cascade value-based approach	Pack to be used to develop integrated model (see 4 below) – starting with pilot in September/October.
2. Establishing a directory of services	<p>Network co-ordinator already produces this but no resources to keep updated/not available to everyone.</p> <p>Action:</p> <ol style="list-style-type: none"> 1. Network Co-ordinator to give database to Age Concern, who will maintain and develop. 2. To be placed on ‘Communityship’ – interactive information/communication system run by CVS to which all professionals will have access. 3. Promotion initially through SSD who currently fulfil care management role – Team Managers Meeting – June. 4. Arrangements to be made for wider accessibility and launch – July. 5. September – particular focus on promotion within develop of integrated teams. 6. Information directly accessed by public is part of Starting Point Service (Single Point of Access into non-mainstream SSD/PCT services).
	<p>Measurement</p> <ul style="list-style-type: none"> ↑ How many professionals access the data base. ↑ Collection of data on unmet need (reduction). ↑ Collection of views on usefulness.
3. Peer Reviews	<p>This should be happening now but to be promoted/developed more formally as part of arrangements for integrated working.</p> <p>Action: Those involved in Complex Care Workshop to promote in workplace. To feed in proposals for wider uptake by September 2005.</p> <p>Measurement: to review frequency/value annually.</p>

On-going Activity from Workshop	Progress
4. Integration of services	<p>Meeting held with key players, based on KF's proposal.</p> <p>Agreed localised pilot based on locality where there is already good practice on close multi-agency working.</p> <p>Development of integrated services is part of Wigan's Local Area Agreement.</p> <p>To involve Voluntary Organisation (Age Concern) – Starting Point – link to POPPs bid for informal services to support crisis e.g. “Difficult Times Project”.</p> <p>Measurement:</p> <p>LAA target monitoring</p> <p>Integrated working is the primary vehicle to achieve the 20% target in reduced bed use, together with application of Chronic Disease Management Strategy (the former being the key process and the latter the re-shaped provision).</p>
5. Broader Context	<p>Integrated working project will include the development of Practice-Based Commissioning, long term conditions, Community matron, active case management.</p> <p>SSD committed to re-structure to reflect LTC agenda (area-based, integrated primary care teams, rather than based on specialisms as at present).</p>
6. Wigan Structures and developments	<p>Wigan has an Executive Steering Group for OP, PCT CE is chair, plus director – level representation from SSD and Acute hospital, plus consultant geriatrician. Reporting to this is a Steering Group with wider representation – private and voluntary sector, pharmacists, providers, etc.</p> <p>Wigan has developed a service model based on the inverted triangle of “All Our Tomorrows”. The workplan covers all levels of the model. A multi-agency, performance report is prepared for each Steering Group. Consideration is currently being given locally to the impact of the 20% target on Payment by Results, as part of the IF work (Resource Release Model).</p>

Draft Action Plan – Tower Hamlets

1.	Applying the values based approach to residents of the Ocean Estate, to discover how to meet their needs better	Santhi & Jane
2.	Looking at the training programme for volunteers working with people with advanced dementia already begun, and to seek funding for this	Richard, Alix & Jane
3.	Consider how to extend training opportunities to care workers who may be employed through Direct Payments	Barbara & Jane

Appendix 4

A Guide to Promote a Shared Understanding of the Benefits of Managed Local Networks ¹⁴ – 2005

Managed local networks have clear governance and accountability arrangements. Because they differ from other types of partnership in this way they can be much more effective in helping to develop multi-professional, multi-agency services that are designed and delivered according to the need of each individual and their family.

Managed local networks are defined in the NSF as:

'linked groups of health professionals and organisations from primary, secondary and tertiary care, and social services and other services working together in a co-ordinated manner' ¹⁵

The specific aim of managed local networks is to encourage all those responsible for delivering care across all agencies, whether private, public or voluntary, or providing health, social care or education services, to work together across agencies to ensure that they deliver more than the individual parts can working alone.

References

1. *Integrated Care: a Guide*, 2004, Integrated Care Network
2. *Department of Health (2005) Supporting People with Long Term Conditions – An NHS & Social Care Model to Support Local Innovation and Integration*, DH: London
3. *Department of Health (2005) Independence, Well-Being and Choice – Our Vision for the Future of Social Care for Adults in England*, DH: London
4. *Department of Health (2005) Creating a Patient-Led NHS – Delivering the NHS Improvement Programme*, DH: London
5. *Department of Health (2001) National Service Framework for Older People*, DH: London
6. *Department of Health (2005) Supporting People with Long Term Conditions – Liberating the Talents of Nurses who Care for People with Long Term Conditions*, DH: London
7. *Department of Health (2005) The National Service Framework for Long-Term Conditions*, DH: London
8. Hutt, R., Rosen, R., McCauley, J (2004) *Case Managing Long-term Conditions – What Impact does it have in the Treatment of Older People?*, Kings Fund: London
9. *Evercare evaluation interim report: implications for supporting people with long-term conditions*, 2005, National Primary Care Research & Development Centre, Manchester University.
10. Woodbridge, K & Fulford, B (2004) *Whose Values? A workbook for values-based practice in mental health care*, The Sainsbury Centre for Mental Health.
11. *Long-Term Conditions*, Modernisation Agency, www.networks.nhs.uk
12. *Clinicians, services and commissioning in chronic disease management in the NHS – the need for coordinated management programmes*, 2004, Report of a joint working party of the Royal College of Physicians of London, the Royal College of General Practitioners and the NHS Alliance
13. *Changing Times – Improving Services for Older People: Report on the Work of the Health and Social Care Change Agent Team 2003/04*, 2004, Department of Health.
14. *Department of Health (2005) A Guide to Promote a Shared Understanding of the Benefits of Managed Local Networks*, DH: London
15. *Department of Health (2001) National Service Framework for Older People*, DH: London

Annex 2

Key Principles for emergency response pathway for people with falls and/or delirium (confusion)

Professor Ian Philp

1. The person may already be known to be at risk or have had previous falls or confusion. Chronic disease management programmes with anticipatory care can be used to head off crisis.
2. In crisis, primary, community and emergency care practitioners can use protocols to identify those people who need not be admitted to hospital and can help mobilise support for the person in their own home.
3. Diagnostic tests are required but if the illness is not life-threatening, these can be undertaken the following day if admitted to hospital or within a few days if the patient stays at home. Use can be made of day hospitals to undertake the diagnostic tests for patients who are not admitted.
4. If the patient is admitted, they should be transferred as soon as possible to a unit specialising in the care of people with these problems, with rapid assessment and treatment on the unit. If the patient has to be admitted to another unit, for example for surgery, there should be a shared care arrangement with old age specialists.
5. If admitted, patients should be discharged as soon as possible to intermediate care services either in their own home or in a step-down unit.
7. Specialist review should be undertaken towards the end of their post acute care to establish a long term management plan. Patients should be put on an at-risk register as problems are likely to recur. Patients and their families should be educated about their condition. The long term management plan should include self care and, in a sub-set who are particularly at high risk, a chronic disease management programme should be put in place which includes anticipatory care.

Annex 3 – PSA Targets

Objectives and Performance Targets

Objective I: Health of the Population

1. Improve the health of the Population. By 2010, increase life expectancy at birth in England to 78.6 years for men and to 82.5 years for women.
 - Substantially reduce mortality rates by 2010;
 - from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
 - from cancer by at least 20% in people under 75 with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
 - from suicide and undetermined injury by at least 20%.

Objective II: Long Term Conditions

4. To improve health outcomes for people with long-term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008, through improved care in primary care and community settings for people with long-term conditions.

Objective III: Access to Services

5. To ensure that by 2008 no one waits more than 18 weeks from GP referral to hospital treatment.

Objective IV: Patient/User Experience

7. Secure sustained annual national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider.
8. Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by:
 - increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and
 - increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.

Annex 4 – list of all the National Service Framework for Older People Standards

Standard One – Rooting out age discrimination

The aim of this standard is to ensure that older people are never unfairly discriminated against in accessing NHS or social care services as a result of their age.

Standard

NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services.

Standard Two – Person-centred care

The aim of this standard is to ensure that older people are treated as individuals and that they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries.

Standard

NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

Standard Three – Intermediate care

The aim of this standard is to provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living.

Standard

Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.

Standard Four – General hospital care

The aim of this standard is to ensure that older people receive the specialist help they need in hospital and that they receive the maximum benefit from having been in hospital.

Standard

Older people's care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.

Standard Five – Stroke

The aim of this standard is to reduce the incidence of stroke in the population and ensure that those who have had a stroke have prompt access to integrated stroke care services.

Standard

The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate.

People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service, and subsequently, with their carers, participate in a multidisciplinary programme of secondary prevention and rehabilitation.

Standard Six – Falls

The aim of this standard is to reduce the number of falls which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen.

Standard

The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their populations of older people. Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through a specialised falls service.

Standard Seven – Mental health in older people

The aim of this standard is to promote good mental health in older people and to treat and support those older people with dementia and depression.

Standard

Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and their carers.

Standard Eight – The promotion of health and active life in older age

The aim of this standard is to extend the healthy life expectancy of older people.

Standard

The health and well-being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils.

There is also a separate Medicines Management booklet.



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